



INSURANCE COMPANY JAMAICA LIMITED

58 Half Way Tree Road
 P.O. Box 631, Kingston 10, Jamaica
 Telephone: 929-8450-1/4, 929-9643-8, Fax No.: 929-2376, 929-6764
 E-mail: genac@cwjamaica.com Website: www.genac.com

TRAVEL CLAIM

POLICY NUMBER:	
----------------	--

Please use **BLOCK LETTERS**

NAME OF INSURED PERSON	
------------------------	--

(If more than one individual is claiming under the same policy, a claim form must be completed for each)

AGE						<i>(To be inserted where a claim relates to injury or illness)</i>
FULL ADDRESS						
BUSINESS OR OCCUPATION						
TELEPHONE NOS.	(w)		(h)		(c)	EMAIL ADDRESS
Have you any other insurance that might cover this claim ?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	If yes, give particulars	

SECTIONS A & E BAGGAGE/ PERSONAL MONEY *Losses under personal money section must be reported to police within 24 hrs.*

Nature and extent of theft, loss or damage and the circumstances under which this occurred, including date and time
(Continue details on page 4 if necessary)

When were police notified?	
Address of Police Station	
What steps have been taken to recover the property and with what result ?	

SECTION A	LIST OF ARTICLES FOR WHICH CLAIM IS MADE	WHERE BOUGHT OR OBTAINED	DATE OF PURCHASE	COST PRICE \$	AMOUNT CLAIMED AFTER DEDUCTION FOR WEAR AND TEAR	
		<i>(Continue on page 4, if necessary)</i>		TOTAL AMOUNT CLAIMED		

SECTION E	DESCRIPTION <i>(i.e. personal money, travellers' cheques, etc.)</i>	AMOUNT CLAIMED

Declaration at the foot of page 3 must be signed

SECTION B PERSONAL ACCIDENT

Date and time of accident			
Where did the accident occur?			
State how the accident occurred and what you were doing at the time			
State as precisely as you can what injuries you sustained identifying right or left as appropriate			
Name and Address of Doctor attending you			
Name and Address of usual Doctor, if different			

How long have you been confined to the house?		Days	Are you still so confined?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
For how long have you been wholly disabled?		Days	For how long partially disabled?		Days

What is your present state of disability?			
To what extent have you been able to attend to business or engage in any occupation since the accident?			

This medical certificate must be completed by the Doctor attending the insured person when a claim is made under Section B. The fee, if any, must be paid by the insured.

I certify that _____
the person described overleaf is suffering from _____
and has been totally/partially unable to work from the day _____
of _____ 20 _____ I expect such disablement to continue for _____ weeks
_____ days from the date shown below.

I am of the opinion that such disablement is the direct and evident consequence of the accident to which the above particulars refer.

Date _____ Signature _____

Address _____

SECTION C CANCELLATION OR CURTAILMENT

State cause of cancellation or curtailment.			
If due to your own illness or injury, please complete Medical Expenses part of Section D below and supply Medical Certificate.			
Have any deposits been recovered?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If not, what steps have been taken to seek recovery?			

Details of cancellation or curtailment charges claimed.	Amount
Total Claimed \$	

SECTION D MEDICAL AND OTHER EXPENSES

<i>MEDICAL EXPENSES</i>	Nature of illness or injury		Duration of illness or injury	
	If illness, state if you have ever suffered from this before.		If so, when (give date)	
	Briefly describe the circumstances of illness or injury			

<i>OTHER EXPENSES</i>	Reasons why other expenses for which a claim is made were incurred.	

Details and nature of medical and other expenses claimed	Amount
Total Claimed \$	

DECLARATION

I hereby warrant the truth of the foregoing statements in every respect.

Date: _____

Signature: _____

(Continuation of SECTION A, if necessary)

(Continuation of SECTION A- List of items for which claim is made, if necessary)